

Iowa Department of Administrative Services – Human Resources Enterprise  
**APPLICATION TO DECREASE SUPPLEMENTAL TERM LIFE INSURANCE**



**Employee Statement**

Employee Name: \_\_\_\_\_

Social Security Number: \_\_\_\_\_

Birth Date: \_\_\_\_\_ Age: \_\_\_\_\_

I want to decrease my supplemental life insurance coverage from my current election to the amount indicated below.

Current Amount of Supplemental Term Life Insurance	Requested Amount of Supplemental Term Life Insurance
<input type="checkbox"/> \$5,000	<input type="checkbox"/> \$0
<input type="checkbox"/> \$10,000	<input type="checkbox"/> \$5,000
<input type="checkbox"/> \$15,000	<input type="checkbox"/> \$10,000
<input type="checkbox"/> \$20,000	<input type="checkbox"/> \$15,000
<input type="checkbox"/> \$25,000	<input type="checkbox"/> \$20,000
<input type="checkbox"/> \$30,000	<input type="checkbox"/> \$25,000
<input type="checkbox"/> \$35,000	<input type="checkbox"/> \$30,000
<input type="checkbox"/> \$40,000	<input type="checkbox"/> \$35,000
<input type="checkbox"/> \$45,000	<input type="checkbox"/> \$40,000
<input type="checkbox"/> \$50,000	<input type="checkbox"/> \$45,000

**REASON FOR CHANGE**

The request to decrease my supplemental term life insurance is due to the following event:

- |   |   |  |   |
|---|---|--|---|
| <input type="checkbox"/> <b>Annual Enrollment and Change Period</b> | <input type="checkbox"/> <b>Change in Your Legal Marital Status</b> | <input type="checkbox"/> <b>Change in the Number of Your Dependents</b>                                    | <input type="checkbox"/> <b>Change in your Spouse's Employment Status</b> |
|   | <input type="checkbox"/> Marriage                                   | <input type="checkbox"/> Adoption or placement for adoption  | <input type="checkbox"/> Spouse terminates employment.                    |
|   | <input type="checkbox"/> Divorce                                    | <input type="checkbox"/> Birth   |   |
|   | <input type="checkbox"/> Legal separation                           | <input type="checkbox"/> Death of dependent  |   |
|   | <input type="checkbox"/> Annulment                                  | <input type="checkbox"/> Dependent is no longer eligible because of age, student status or marital status. |   |
|   | <input type="checkbox"/> Death of spouse                            |  |   |

I understand that if I decide to increase supplemental life insurance coverage at a later date, I will only be able to increase my coverage during the annual enrollment and change period unless I experience a qualified life event. In addition, I will have to provide evidence of insurability and be approved for coverage by Hartford.

I authorize the State of Iowa to deduct from my earnings supplemental life insurance premiums under a contract issued by the The Hartford Insurance Company.

I declare the above information is true and understand it is the basis for determining the any changes.

Employee Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Employee: After signing and dating, give this form to your Personnel Assistant.**

**Employer Statement**

Personnel Assistant Name: \_\_\_\_\_

Employee's Current Life Code: \_\_\_\_\_

When completed, send the form to:

Iowa Department of Administrative Services – Human Resources Enterprise  
Group Life Insurance  
Hoover State Office Building  
Des Moines, IA 50319-0150

**DAS-HRE Use Only**

Effective Date: \_\_\_\_\_

Change Code from \_\_\_\_\_ to \_\_\_\_\_